

UNIFYING IOWA'S HEALTH CARE DELIVERY SYSTEM PROJECT NARRATIVE

A. State Health Innovation Plan Design Strategy

Iowa's health care system consistently ranks among the top five states in the nation for cost effectiveness and quality¹. However, despite these rankings, commercial premiums for families and employers, and the state's funding obligations for Medicaid, continue to rise at unsustainable levels. The system is not meeting quality and patient outcomes we would like to achieve. This fact reveals an underlying problem within the US health care system, which drives ever escalating costs: the lack of a coordinated and systematic care delivery process focused on volume of procedures rather than patient outcomes.

In addition, Iowa has a growing need for health care professionals. Although Iowa has a strong and growing primary care physician workforce, the non-primary care workforce has not grown with the needs of the state. Iowa has particular need for psychiatry, neurosurgery and obstetrics/gynecology. There is also a critical need for non-physician health care professionals due to our aging population and the soaring costs of care.

Recognizing these challenges, Governor Terry Branstad convened a workgroup of health care leaders over a year ago to develop recommendations that would address the rising cost of health care and ensure Iowans are healthier. This workgroup included the state's largest health care providers, both medical schools, the state's largest commercial insurer, Medicaid, and

¹ <http://www.commonwealthfund.org/Charts/Report/Aiming-Higher--Results-from-a-State-Scorecard-on-Health-System-Performance/S/State-Ranking-on-Access-and-Quality-Dimensions.aspx>

other state leaders. The recommendations of that group involving health care delivery reform are embodied in this application.

State Health Care Innovation Plan Goals and Strategies

Iowa is committed to achieving better health, better care and lower costs for Iowa patients.

Iowa's State Health Care Innovation Plan will focus on the following goals and principles:

Vision: Transform Iowa's health care economy so that it is affordable and accessible for families, employers, and the state, and achieves higher quality and better outcomes for patients.

- **Economically Sustainable:** Implement integrated care models that ensure coordination of health care delivery for persons with chronic disease, disabilities, and long term care needs, that lower cost and improve outcomes and patient satisfaction.
- **Accountability:** Develop appropriate incentives to move from volume-based to value-based purchasing, and reward achievement of cost, quality, and patient satisfaction outcomes.
- **Aligned Payment and Quality Strategies:** Align payment methods and quality strategies between Iowa's key health care payers to ensure a unified set of outcomes.
- **Patient-focused:** Improve Iowan's health and wellbeing and allow them to take ownership over their health decisions.
- **Workforce:** Assure the adequacy of Iowa's health care workforce.

Goal: Through the strategies described below, Iowa's goal is to reduce the rate of growth in health care costs for the state as a whole to the Consumer Price Index within 3 years. The goals for the ACO organizations will be more aggressive, to reduce costs by 5-8% within 3 years.

Strategy 1: Implement a multi-payer Accountable Care Organization (ACO) methodology across Iowa's primary health care payers.

Iowa's first strategy for implementing integrated care models is to implement a multi-payer Accountable Care Organization (ACO) with aligned performance measures, shared savings methodology, and integrated information technology (IT) platform to support the ACOs. This strategy includes Iowa's largest commercial payer and Medicaid -- who together cover 70% of Iowans. Iowa will seek Medicare participation also, which would bring total lives covered to 86% of Iowans. Our large health care systems need enough 'critical mass' in order to move their organizations whole-scale to population based care. They need the leverage and consistency to reorganize, since they need to manage the financial impacts of reductions in usage of hospital care. We believe this strategy will provide enough leverage to encourage provider delivery systems to change their business models, which will benefit all Iowans, regardless of payer.

Iowa's largest commercial payer, Wellmark Blue Cross Blue Shield, covers approximately 1.7 million Iowans. Wellmark Blue Cross and Blue Shield is a mutual insurance company owned by its policyholders. Wellmark has developed a shared savings ACO model and has executed contracts with the three largest Iowa hospital/physician health systems.

Wellmark's Accountable Care Organization Payment Arrangements

Wellmark began working closely with key integrated health systems in Iowa in 2011, on a framework for a value-based reimbursement model. In 2012, Wellmark executed collaborative accountable care organization (ACO) payment arrangements with three health systems across Iowa. The ACO arrangements are 5-year agreements focused on improving the health care experience and slowing the rate of increase in health care costs for the Wellmark members who

are attributed to these ACOs. The ACO arrangements have been created to keep healthy people well and improve health outcomes for our members when they need care. Wellmark is collaborating with the following health systems:

- Iowa Health System hospitals, affiliated medical clinics, and other health care professionals and facilities in the following communities: Cedar Rapids, Des Moines, Fort Dodge, and Waterloo. 167,058 lives are attributed to this ACO.
- Mercy Medical Center in Des Moines and affiliated medical clinics and other health care professionals and facilities. 67,938 lives are attributed to this ACO.
- Genesis Health System in Davenport and affiliated medical clinics and other health care professionals and facilities. 19,672 lives are attributed to this ACO.
- Wellmark is currently working with additional providers systems to enter into ACO contracts and estimates that 2-3 additional ACOs will be under contract within the next year, with approximately 50,000 lives attributed to these additional ACOs.

Wellmark's ACO strategy will enhance Wellmark members' care in a variety of ways:

- Quality outcomes – Keep healthy people well and improve the outcomes for Wellmark members when they need care.
- Better experience/more informed patient – Ensure all appropriate care is received timely and patients are actively engaged in the care they receive and understand the costs.
- Reduce the rate of increase – Wellmark will support participating providers' efforts in lowering costs without compromising care. In addition, Wellmark will share any cost savings with the ACOs.

These goals are reflected in the design of the ACO arrangements, the key attributes of which Wellmark and participating providers believe serve as a good starting point for transforming health care delivery and financing in Iowa:

- Effective primary care as the foundation – emphasizing primary care will improve outcomes, experience of care, and costs of care.
- Enhanced risk adjustment – applying more advanced methods of measuring illness burden.
- Quality over cost containment – success should be achieved through improving care infrastructures, processes, and management as well as member engagement and not by withholding care.
- Data and tools – providing sophisticated, yet functional, data reporting to support ACO provider participants in better understanding and managing risk associated with their attributed Wellmark members.

ACO members are attributed to primary care physicians using a primary care based attribution logic developed by Wellmark. This model is based on the CMS attribution method. The ACO payment arrangement is risk-adjusted using the 3M Clinical Risk Groups (CRGs). CRGs are a population classification system that predicts the amount and type of health care services that attributed members have used in the past (retrospective) or can be expected to use in the future (prospective). CRGs can provide the basis for a comparative understanding of severity, treatment, best practice patterns, and disease management strategies – which support efforts to control costs, maintain quality, and improve outcomes.

ACO Quality and Payment Design

Payments under the ACO arrangement are in addition to the fee-for-service payments due to the ACO provider participants for covered services and are comprised of a shared savings component and a quality incentive component. Within the ACO arrangement, Wellmark and the provider participants have prioritized quality over cost containment. Thus, to qualify for any shared savings payment opportunity, certain quality measures first must be equal to or better than target. The measures that “trigger” the ACO’s shared savings opportunity are the measures that comprise the Quality Index Score (QIS) SM.

The ACO payment arrangement is a two-sided shared savings/losses model with options for the ACO to select 50, 60 or 70 percent of the shared savings or losses. If the shared savings trigger is achieved and the ACO’s actual total cost of care per-member per-month (PMPM) is less than the target PMPM for a performance year, savings are shared based on the option selected. The ACO has an opportunity for additional shared savings payment if the actual PMPM approaches the Consumer Price Index target. Shared losses are not applicable until Performance Year 3.

The QIS, developed by Treo Solutions (Treo), represents a single composite score of quality measures within the following six domains: Attributed Member Experience, Primary and Secondary Prevention, Tertiary Prevention, Population Health Status, Continuity of Care, and Chronic and Follow-up Care.

The data management and analytics supporting Wellmark’s ACO payment arrangements are administered by Treo Solutions. Wellmark has a long standing relationship with Treo and Iowa providers are familiar with the Treo tools. Treo has a long history of helping health plans, state

governments and health systems develop payment models and analytic platforms to support real delivery system reform that focuses on managing Total Cost of Care (TCC). Specifically, Treo is providing performance dashboards, reports, and data to the ACO provider participants to assist them in determining opportunities for care infrastructure and process enhancements.

The work Treo is doing with Wellmark to support the ACO payment arrangements in Iowa is very similar in structure to programs that are currently underway with several Medicaid and Medicare programs in other parts of the country, several of which are part of multi-payer initiatives.

Iowa Medicaid Program

Iowa Medicaid covers an average of 400,000 Iowans in the regular Medicaid program. Iowa's program is primarily fee-for-service with a managed care behavioral health carve-out. Due to the high degree of 'unmanaged' fee for service, there is great potential for ACOs to have an impact on cost and quality for Medicaid members.

Iowa Medicaid was among the first states in the nation to implement the health home state plan option July 1, 2012. Iowa Medicaid has been monitoring the development of ACOs in Iowa and took advantage of the health homes option as an opportunity for Medicaid to invest in the development of necessary core infrastructure for population health management, care coordination, and patient-centered care in Medicaid primary care practices. As of August 2012, and only two months into the program, 10 health home entities, with 40 clinic locations, and 467 individual providers are enrolled health home providers, with 671 members now enrolled. 47% of the members enrolled are dual eligibles.

Multi-payer ACO Strategy

The model proposed in this application further increases integration of care and improved outcomes beyond what can be achieved by a Medicaid health home strategy alone. Following the lead of the private sector, Iowa Medicaid will utilize the Wellmark ACO model, including consistent performance metrics and payment methodologies, and a single IT platform to support ACO management and tracking for the providers. The ACO model provides a contractual accountability framework for the larger health care system – so hospitals, specialists, home health, and nursing facilities are all working toward the same end result: better care, better health and at a lower cost. The potential is greater than if the health homes try to engage other providers to coordinate care voluntarily. In the ACO, the hospitals, specialists, and other providers part of that contracted ACO will all be working toward the same accountability measures and outcomes.

We anticipate that ACOs contracted with Medicaid will include health home entities receiving health home payments. Therefore, the model design must also include more perfectly aligning the Medicaid health home measures and policy with the ACO that is developed, because the ACO will be ultimately accountable.

Iowa intends to include its Children's Health Insurance Program in the ACO development. Iowa has a combined CHIP program covering 60,000 children, in which premiums are paid to two commercial health plans for the delivery of CHIP benefits: Wellmark and United Healthcare. Iowa will include these CHIP plans in the ACO model.

Model Design Strategy for Strategy 1

- Medicaid's goal is to include all Medicaid and CHIP populations (approximately 400,000 for Medicaid and 60,000 for CHIP) in the ACO structures over three years.
- Iowa Medicaid will contract with Treo Solutions to provide consulting, data modeling, and support in finalizing measures and the shared savings methodology for Medicaid.
- Treo will provide a single data system, including a dashboard to track and monitor performance to support Iowa ACO organizations. Using the same vendor will ensure alignment of the methodology. Using the same methodology will allow providers to focus on a single set of performance metrics.
- Wellmark and Medicaid will collaborate in supporting ACO learning collaboratives to speed adoption of lessons learned and best practices among ACOs.
- Iowa will collaborate with existing quality interventions in Iowa.
 - Iowa is one of two states in the country with a 100% hospital participation in CMS's Hospital Engagement Network (HEN) initiative promoting quality through programs like the Partnership for Patients and the Million Hearts Campaign.
 - The Iowa HealthCare Collaborative is overseeing the Iowa HEN and has organized a two year strategy to engage hospitals and improve quality in 10 key areas.²
- Medicaid will develop an implementation plan, including how the ACOs will contract with Medicaid, and a strategy to ensure statewide adoption. Medicaid anticipates either contracting with the ACOs already under contract with Wellmark, or potentially developing a procurement that would allow for competitive bidding to be an ACO in regions, such as

² Additional information can be found at: <http://www.ihconline.org/aspx/newsdetail.aspx?nid=40>.

recently done in Colorado. The model design activities will determine the best strategy for Iowa, and also determine necessary state plan amendments and/or Medicaid waivers.

- Medicaid will explore the role of managed care plans and expansion of managed care in Medicaid as part of the ACO planning.
- Iowa will seek to design a rural model for ACO. Iowa is a rural state, and to achieve statewide or near statewide adoption of ACO, Iowa will need to develop a model for rural areas.
- Iowa will seek the participation of Medicare in this strategy as a multi-payer partner. Iowa will work with CMS to explore alignment of Iowa's ACO with Medicare, including Iowa's Pioneer ACO, Trinity (a component of Iowa Health System). Several other Iowa organizations either are or working to form Medicare ACOs. Iowa will include 70,000 dual eligibles in the Medicaid ACOs, and will include Medicare claims data in the Treo analytics tools, if permitted by CMS.

Strategy 2: Expand on the multi-payer ACO methodology to address integration of long term care services and supports and behavioral health services.

Iowa Medicaid covers the majority of long term care services and supports for older Iowans and Iowans with disabilities, including dual eligibles (individuals covered by both Medicare and Medicaid). It has been well documented that these populations particularly suffer from fragmented delivery systems of care, resulting in very high cost and poor outcomes. Iowa will expand the current ACO model to integrate long term care and community based organizations into the value-based framework. This effort will reduce duplication of effort and increase use of home and community based services, thus lowering use of more costly institutional services.

The systems involved for older Iowans and Iowans with disabilities include the traditional system of physicians and hospitals, long term care providers, and community based outreach providers. Iowans who get help from all of these sources do not understand who does what for them or why. All of these entities may provide some sort of 'case management' that only encompasses a fraction of the needs for the person and do not coordinate. The result is duplication of effort, everyone working at misaligned or perhaps cross purposes, and none focused on the full aspects of that persons' situation.

The success of ACO models in Medicaid will be determined by our success in being able to integrate care for these highest cost/ highest risk populations, with very intense needs for social and community based supports. These populations and services are generally not covered by commercial insurance and therefore have not been fully addressed in commercial or Medicare ACO models. Medicaid is the primary payer for health and community based supports for persons with disabilities, providing sufficient leverage to influence delivery system change. Iowa plans to use the model design phase to develop strategies to integrate community health and community prevention activities in their multi-payer models to build on the ACO model in three key areas:

Model Design Strategy - Integration with Long Term Care

- Iowa will develop models for how nursing home and HCBS waiver services for the Elderly Waiver and persons with physical disabilities (including dual eligibles) are integrated or connected with ACOs. Medicaid members receiving long term care services (including dual eligibles, but excluding persons with Intellectual Disabilities) will be included in the ACO.

The goal is to reduce hospital readmissions and shift utilization from institutional care to

home and community based care, lowering overall costs. We project this activity would impact 26,600 Medicaid members served in nursing facilities, the Elderly HCBS Waiver, and the Physical Disabilities HCBS Waiver.

- We will engage with long term care providers. The Iowa HealthCare Association (IHCA) is working with long term and post-acute care providers in Iowa to decrease hospital readmissions by 15% over a three year period.
- Dual eligibles. The ACO development as well as the activities of ensuring integration of long term care will also have a specific focus on Iowa's 70,000 dual eligibles.
- Develop how the Aging Disability Resource Centers (ADRCs) and other community outreach entities, such as Title V and Community Action agencies, are connected with ACOs to ensure maximum integration. We do not want ACOs to expend resources to duplicate the community outreach, navigation, and other resources that already exist. We seek to find ways to increase coordination among these entities.
 - We will collaborate with the Iowa Department on Aging, the Iowa Health Care Collaborative (Iowa's HEN overseer) and the Iowa Hospital Association to educate acute care providers about these services and develop specific processes that ensure coordination and integration can occur. This avoids duplication of the same services from the acute care system.
- The work to integrate long term care services with the ACOs will coordinate with Iowa's BIPP design and address BIPP requirements for a single point of entry system for services, standardized assessments, and conflict-free case management. These elements of BIPP are

also critical to streamlining and ensuring appropriate coordination and navigation for individuals, supporting the goals and larger strategy outlined in this proposal.

Integration for Persons with Disabilities

- Develop integrated care models for children and adults with severe and persistent mental illness (including dual eligibles). We project this will impact 25,000 adults with SPMI (40% of which are dual eligibles), and 8,000 children with Serious Emotional Disturbance.
 - Iowa is finalizing a second health home state plan amendment for persons with SPMI to be submitted in early 2013. The specialized health homes will be implemented through Iowa's behavioral health managed care plan (contracted to Magellan). The model design activities will focus on how the SPMI health homes will be coordinated and integrated with the ACO model to achieve better outcomes.
- Exploring integrated care models for persons with intellectual disabilities. This population will not be covered by the ACOs initially. The model design phase will focus on researching how this population could be better served and included at a later date.
 - For the past two years, Iowa has been engaged in a significant redesign of its mental health and disability system (MHDS) for adults. The previous county-led system is being reformed over the next two years into a regional system with accountability to the state for implementing statewide core services and outcomes for patients. The model design activities will focus on exploring the role of the new regions, connecting them with the ACOs, and on how individuals with intellectual disabilities could be more effectively served through integrated care models.

Strategy 3: Population health and health promotion

In Iowa, we believe that true health care reform must be led by individuals becoming healthier and taking ownership of their own health and well-being. Governor Terry Branstad has set the goal for Iowa to become the healthiest state in the nation by 2016 according to the Gallup Healthways Well-Being Index. The Healthiest State Initiative is a privately led and publicly endorsed partnership that includes Wellmark and the State of Iowa.³ This initiative seeks to improve the health of individuals by encouraging active lifestyles and healthier choices. Additionally, through Wellmark, communities across Iowa are coming together to lead and ignite community-by-community well-being transformation utilizing the evidence-based Blue Zones.

The Blue Zones ProjectTM, a key component in our mission to becoming the healthiest state, takes an environmental approach to well-being.⁴ Wellmark has committed to providing large and small Iowa communities with the tools they need to be better equipped for active living. Focused on sustainable change, The Blue Zones Project seeks to engage Iowans at a grassroots level in redesigning their environments through lasting changes to the physical environment, policies, and social connections to ultimately make healthier choices easier.

The Healthiest State Initiative has already achieved success in empowering and activating Iowans across the state. In October 2011 more than 291,000 Iowans, in all 99 counties, walked one kilometer in the Start Somewhere Walk. Since that initial success, 84 communities in Iowa submitted proposals to become Blue Zones with four large communities on the path to becoming Blue Zones.

³ For more information, please see: www.IowaHealthiestState.com

⁴ Additional information can be found at: www.BlueZonesProject.com

The Healthiest State Initiative is bringing out the best in both the public and private sectors. By Iowans simply taking greater ownership of their health and individuals making lifestyle changes to become more active and well, Iowa could re-direct as much as \$16 billion over the next five years instead of those resources being consumed by health care and lost productivity.⁵ Empowering Iowans and making Iowa the healthiest state in the nation is not only critical to the economic viability of our state, but critical to the quality of life for all Iowans.

With this core philosophy in mind, Iowa seeks to include elements that encourage personal responsibility for individuals to take ownership for and be incented to improve their own personal health and well-being. Iowa is encouraged by the success of programs such as Indiana's POWER accounts. We will include a design for providing financial and other incentives to Medicaid members that adopt healthy behaviors in our State Innovation Plan and Model Testing Proposal. Incentivizing behaviors that improve their health status through weight loss or improvement in the management of their chronic disease, access appropriate preventative services and preventing the overuse of emergency services is critically important to Medicaid members and the sustainability of Medicaid. The specifics of this design are to be developed as part of the model design phase. Iowa will utilize the technical assistance vendor to research best practices and develop a model for Iowa.

State Health Care Innovation Plan and Model Testing Strategy

Iowa will develop a State Healthcare Innovation Plan by June 4, 2013 that addresses the three strategies described above and will define the elements required in the Cooperative Agreement. The Plan will include the specific design features of each strategy, as well as a

⁵ World Economic Forum Website, Wellness App; wellness.weforum.org, 03-02-2011

detailed implementation plan describing specifically how these strategies will be implemented and timeframes. The State will work with CMS and the technical assistance offered by CMS to determine the waivers and state plan amendments that will be needed, which will also be included in the Innovation Plan. The State will also produce the Model Testing proposal that will be submitted to CMS to support the implementation and testing of the strategies, including detailed timelines.

B. Stakeholder Process

The Iowa Department of Human Services (DHS), the single state Medicaid agency, will lead the stakeholder engagement process. The process for engaging stakeholders in the Model Design and development of the State Healthcare Innovation Plan has six elements:

1. **Advisory Committee** – Governor Branstad will appoint an advisory committee, building on the Administration’s former work and made up of key stakeholders to guide the development of the design model and implementation plan.
2. **State Legislative Process** – Legislative authorization will be required to authorize the strategies proposed for the Medicaid program. DHS will draft this legislation. The Iowa Legislature begins meeting in January 2013. By passing the strategies embodied in this proposal through the Legislature, the proposal will be thoroughly vetted by state policymakers and all of the stakeholders impacted.
3. **Local Listening Sessions** – DHS will partner with local entities across the state to convene at least 5 public meetings at the local level to present the model design concepts to stakeholders. DHS will seek input from stakeholders at these meetings about their thoughts and concerns with the current system and how they interact with the current system, and

improvements that could be made. We plan to invite local hospitals, physicians, nursing facility providers, long term care providers, county representatives, case managers, local public health agencies, Area Agencies on Aging, constituents and consumer advocacy organizations.

4. Children's Disability Workgroup –The group consists of the DHS, provider groups, consumers, and other child-serving agencies. The workgroup's charge is to develop an integrated system of care for children with disabilities. The workgroup led the development of the Medicaid specialized health home model for children and adults with serious and persistent mental illness (SPMI) using a Systems of Care model. DHS will present the model design plan and strategies to the workgroup to seek their input.
5. DHS will collaborate and seek input from provider and consumer organizations:
 - DHS will collaborate with the provider systems interested in forming ACOs in developing the multi-payer payment methodologies and measures. This includes but is not limited to: Iowa Health System (including the Pioneer ACO project), Mercy Health System, Genesis Health System, Broadlawns Medical Center, University of Iowa Hospitals and Clinics, and the Safety Net Collaborative (representing FQHCs and Rural Health Clinics). This activity will include collaboration with the Iowa Health Care Collaborative, as Iowa's HEN coordinator, Iowa Hospital Association, Iowa Medical Society, Iowa Family Practice Physicians, Iowa Osteopathic Medicine Association, and Iowa Primary Care Association.
 - Partnering with the Iowa Department on Aging, DHS will also plan specific meetings with long term care services and supports providers to collaborate on the development of the design model for integration of long term care services, including the strategies involved in

the BIP plan such as independent assessments, no wrong door, and conflict-free case management. These provider groups include but are not limited to: nursing facilities, Area Agencies on Aging, Targeted Care Management, Counties, Iowa Behavioral Health Association, Iowa Association of Community Providers, and Home Health Association.

- DHS will meet with organizations representing consumers. DHS will initiate meetings with these groups to discuss the current system, problems and barriers, discuss the model design and innovation plans and how the proposed changes could improve the system. These organizations include but are not limited to: the Olmstead Task Force (includes consumers and members representing consumers with disabilities), Mental Health Planning Council (includes consumers with mental health conditions, family members, and mental health providers), DHS Council, American Association of Retired Persons, American Cancer Society, Partnership for Better Health, Child and Family Policy Council, and the Medical Assistance Advisory Council.
6. The Iowa Department of Public Health (IDPH) will continue working with both of the state's medical schools and the Iowa Health Professions Tracking Center in the Carver College of Medicine to examine health care professional shortages. These meetings will include organizations representing physicians, nurses, physician assistants, pharmacists and hospitals.

C. Public and Private Payer Participation

As noted above, Medicaid, Wellmark and Medicare cover the vast majority of Iowans. Medicaid and Wellmark are partnering in this proposal to develop a multi-payer ACO model. We will also seek Medicare's participation. Specifically, multi-payer participation includes:

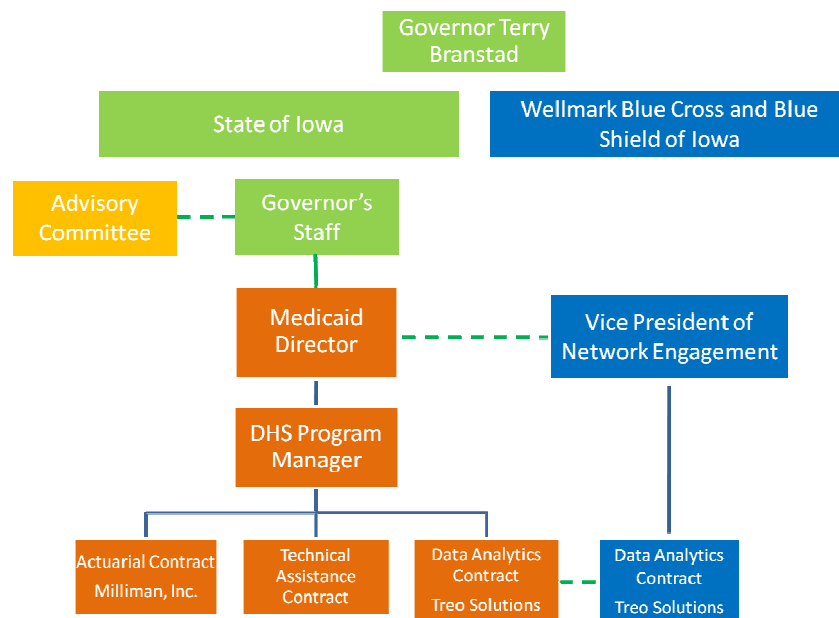
- The Iowa Medicaid and CHIP programs, administered by the Iowa Department of Human Services. Iowa Medicaid is committed to partnering in a multi-payer ACO model for Medicaid providers. DHS/Iowa Medicaid is committed to leading the model design process and development of the State Healthcare Innovation Plan, under the policy guidance and direction of the Governor's Office. DHS/Iowa Medicaid will lead the stakeholder engagement effort, and efforts to integrate long term care services and supports, and SPMI population strategies within the multi-payer strategy. DHS/Iowa Medicaid will lead the coordination with other key partners such as Iowa Department on Aging, provider organizations, and consumer organizations.
- Wellmark Blue Cross and Blue Shield of Iowa. Wellmark is committed to working with the state in providing technical assistance and partnering on using the Treo Solutions products to provide an integrated data and analytics platform for supporting a multi-payer ACO methodology. Wellmark and the state will partner on developing analytics and metrics that support broad system level quality improvement for providers and population health.
- Iowa seeks Medicare participation. Medicare, Wellmark and Medicaid together cover approximately 85% of Iowans. Iowa seeks the maximum alignment possible in the ACO reimbursement method and alignment for the quality metrics. We will partner with Medicare ACOs in Iowa, including the Pioneer ACO. At a minimum, Iowa will include dual eligibles in the ACO, and would like to include Medicare claims data in the analytic tools.

D. Project Organization

DHS will oversee administration of Iowa's Model Design project and funding, under the lead and policy guidance of the Governor's Office, and in partnership with Wellmark. The key project

leadership will be provided by Jennifer Vermeer, Iowa DHS Medicaid Director, and by a full time program manager that would be funded by the grant (to be hired). Management from the Governor's Office will be provided by Michael Boussetot, health care policy advisor to the Governor. Wellmark's participation will be led by Tom Newton, Vice President of Network Engagement. The advisory committee, which is comprised of public and private sector leaders, will help guide policy formation in relation to the needs of the market.

Figure 1. Project Organizational Structure



DHS/Medicaid will enter into a sole source contract with Treo Solutions to provide the data analytic support for both Medicaid and Wellmark, as described above. Medicaid will issue a Request for Proposals to contract with a vendor to provide technical assistance (TA) in developing any Medicaid waivers, state plan amendments, and procurement documents necessary to implement the program. The TA vendor will support the stakeholder process and drafting of the State Innovation Plan and Model Testing proposal. Medicaid will use its current contract with Milliman for actuarial services to analyze the expected financial impacts and

develop the financial model needed for the Testing proposal. Medicaid and Wellmark will rely on existing vendors and staff to provide all other support needed for the program, using primarily existing resources for the model design phase.

E. Provider Engagement

The State of Iowa is an ideal place to test delivery system transformation. The system is characterized by a relatively small number of large entities that are already working together: three payers (Wellmark, Medicaid and Medicare) provide coverage to a vast majority of Iowans (86%); a small number of very large integrated health systems deliver the majority of acute care services and employ approximately 70% of the primary care physicians in the state; and Iowa has very good rates of insurance coverage, consistently in or near the top 10 states depending on the methodology. Examples of how providers and payers are already engaged are provided below.

Iowa's health care delivery system is influenced by a small number of large integrated health systems. These systems include a network of large and small hospitals, employed primary care and specialist physicians, and other ancillary services. These large systems provide a significant amount of acute care delivery in Iowa. For example, the three ACO systems currently contracted to Wellmark provided services to approximately 25% of the Medicaid population last year. The systems are already engaged in transforming their delivery systems to function as ACOs, evidenced by those already under ACO contracts with Wellmark. One of those systems contracted with CMS as a Pioneer ACO, and all three are participating in the Medicare shared savings program. As described above, Wellmark collaborated with these large systems for two years in developing their ACO model. Wellmark is working other systems to

enter into ACO contracts and believes another 2-3 will be contracted within the next year, including the state's University hospital system.

These same three large systems, along with Wellmark, have provided leadership in the development of Iowa's Health Information Exchange (the Iowa Health Information Network). Wellmark, Iowa Health Systems, Mercy and Genesis have signed memorandums of understanding committing to financial support and participation.

In addition, every hospital in Iowa is participating in the Partnership for Patients program with CMS, which is supported by the Hospital Engagement Network administered by the Iowa Healthcare Collaborative. These efforts are all geared toward decreasing hospital errors and reducing hospital readmissions irrespective of payer, and are well aligned with the larger goals of ACO development and integrated care models.

The state's two large public safety net hospitals and 6 of Iowa's 13 Federally Qualified Community Health Centers act as medical homes for over 60,000 adults enrolled in Iowa's 1115 Waiver IowaCare. The FQHCs, DHS and the University of Iowa Public Policy Center are also engaged in a NASHP Learning Collaborative that is intended to maximize participation of safety net providers in health homes, develop strategies to better integrate primary and behavioral care for individuals with chronic disease, and to develop ways that safety net providers can be engaged in value-based purchasing models, such as ACOs.

For long term care, Iowa's nursing facilities are engaged in quality projects aimed at reducing hospital admissions; and the Iowa Department on Aging has restructured the Area Agencies on Aging to become ADRCs, with an eye toward integrated, whole person coordination of care.

Over the past eight years, Wellmark has actively engaged both primary care clinicians and hospitals in performance measurement and improvement. Since 2004, Wellmark has engaged primary care clinicians in quality improvement and management of chronic conditions, such as diabetes and hypertension, with the quality-based incentive program, Collaboration on Quality® (CoQ). By 2008, half of the primary care clinicians in Iowa were participating in CoQ – using an electronic data registry to identify attributed members with needed care for proactive outreach. Also in 2008, Wellmark began working with Treo Solutions to provide hospitals in Iowa data on Potentially Preventable Events, including potentially preventable readmissions, for their facilities for quality improvement purposes.

Provider Engagement

Building on the efforts described above, we will collaborate with providers in the three strategies described in Section A and using the stakeholder process described in Section B. Providers will be engaged in the model design and future model testing in the following ways:

- The state will collaborate with the three large systems under contract with Wellmark to adopt Wellmark’s model for Medicaid, and continuing to engage with more ACOs.
- The state will collaborate with Wellmark’s Network Engagement team, a functional unit responsible for working with providers – using a consultative approach to assist providers with interpreting their quality and financial data and identifying opportunities to positively impact quality of care, which in turn will improve patient outcomes and reduce total cost of care. Wellmark’s Network Engagement team is able to bring expertise in provider engagement and established provider relationships to bear as value-added contributions to the State Innovation Model design process.

- The state will engage with other large Medicaid provider systems, such as the state's two large public, safety net hospitals (Broadlawns Medical Center and University of Iowa Hospitals and Clinics) in becoming Medicaid ACOs. Both entities have demonstrated commitment to population health models through their participation in Medicaid medical home strategies and strong interest to participate in the ACO program.
- The state will build on efforts started from Iowa's participation in the NASHP Safety Net Learning Collaborative. Iowa Safety Net providers are engaging in Health Home programs and active and interested in building value-based purchasing systems in Iowa.
- The state will engage with long term care providers such as nursing facilities, home health and HCBS providers in developing the strategies for how these services can be more effectively coordinated with the ACO models.
- We will engage with providers of services to persons with mental health and substance abuse conditions in developing the strategies for integrating physical and behavioral health care. See the discussion above about the recent MHDS Redesign efforts, Children's Disability Workgroup, and Specialized Health Home development.

In conclusion, providers across the health care spectrum are engaged and committed to transforming the delivery system. The intent and commitment is there, we need to align payment systems and metrics to support transformation; and those efforts are underway. Iowa has a small enough number of key partners that cover a broad enough population to really get things done, but we are large enough to provide a true test of delivery reform models. We believe the design strategy and Innovation Plan developed will provide sufficient leverage and tools to achieve true change in our health care system.

UNIFYING IOWA'S HEALTH CARE DELIVERY SYSTEM PROJECT PLAN AND TIMELINE

The proposed project plan contains four distinct phases and each phase has well defined milestones and deliverables. The phases are: Project Start Up, Model Definition, Stakeholder Feedback, and development of the State Health Care Innovation Plan. Tasks and start and end dates are described in the table below. Due to the short timeframe for the Model Design project, all procurement efforts other than finalizing contracts will be initiated prior to the SIM award date.

Task Name	Start	Finish
Project Start Up	10/15/12	12/31/12
Finalize Treo & Milliman Contracts	10/15/12	12/4/12
Procure Technical Assistance Vendor	10/15/12	12/15/12
Award of Model Design Funding		12/4/12
Hire Program Manager FTE	12/4/12	12/31/12
Appointment of Advisory Committee		12/14/12
Model Definition	12/4/12	3/29/13
Define Treo/State Data and Security specifications	12/4/12	12/10/12
Medicaid data feed to Treo	12/4/12	12/21/12
Treo Data Center Set-up – Data mapping, data integration including Medicaid claims and dual eligibles' data	12/4/12	1/1/13
Treo Data Development - member, provider identification and mapping	12/4/12	1/1/13
TA Vendor Contract Initiation		1/1/13
Treo Data QA, aggregation, attribution, creation of dashboards	12/21/12	2/15/13
Milliman Financial Impact Report	12/4/12	2/1/13
Draft Model Design Document	1/1/13	2/15/13
State of Iowa and Wellmark Review	2/15/13	2/22/13
State Plan / Waiver development and definition	2/15/13	3/29/13
Stakeholder Feedback	1/1/13	3/31/13
Advisory Committee Meeting		Week of 1/11/13
Legislative Hearings: HHS Appropriations, Human Resources Committees	2/1/13	3/31/13
Advisory Committee Meeting		Week of 3/4/13
Meetings with stakeholder organizations	2/1/13	4/30/13
Local Listening Meetings	2/1/13	5/15/13

Legislation Enacted	4/1/13	4/30/13
Advisory Committee Meeting		Week of 4/5/13
Advisory Committee Meeting		Week of 5/31/13
State Health Care Innovation Plan	3/1/13	6/3/13
Milliman Financial Models for Testing Proposal	2/1/13	4/30/13
Plan /Model Testing Proposal Drafts	3/1/13	5/15/13
State of Iowa and Wellmark Review	5/15/13	5/22/13
Plan Submission		6/3/13
Model Testing Proposal Submission		6/3/13

The Project Start Up phase 10/15/13- 12/31/12 will involve contract procurement, negotiation and hiring the Program Manager FTE. Contract scope is described below:

- Treo Solutions – DHS will enter into a sole source contract (including Business Associate Agreement) with Treo Solutions to provide a consolidated platform for the multi-payer ACOs. Scope of work will define data transfers, data analysis, analytic tools, a dashboard for use by Medicaid and the ACOs, and assistance in fully defining the ACO methodologies for Medicaid including the model enhancements outlined in Strategy 2. Medicaid will work with Treo and Medicare to include Medicare Part A, B and D data in Treo’s data warehouse to be used in the analytics that will support ACO management of dual eligibles. Medicaid 1915(b) managed care encounter data will also be brought into the Treo warehouse so that it can be incorporated into the metrics and dashboards that will support the ACOs, for the purpose of a fully informed cost of care measure.
- TA Contract – Medicaid will conduct a competitive procurement for the Technical Assistance (TA) vendor. The TA vendor contract scope of work for the grant will include: technical assistance in model design, especially the enhancements outlined in Strategy 2; support in determining necessary State Plan Amendments and/or Waivers; writing documents for CMS review; and supporting the State in implementation planning. The

scope will include an optional piece for developing procurement documents if determined necessary. The TA contract will also include support in developing the State Health Care Innovation Plan and Model Testing Proposal.

- Milliman – Medicaid will use its current contract with Milliman for actuarial services to provide a detailed financial analysis of the impact of the Model design proposal and to develop the financial models needed to complete the Model Testing Proposal.
- Program Manager FTE – To be hired by Medicaid by December 14, 2012.

The Model Design phase 12/4/2012 – 3/29/2013 includes establishing data transfers with Treo, loading data into Treo's warehouse, cleaning the data so that it will work in the data models, setting up analytics and dashboards. Medicaid will work with Treo to develop analytics that support the inclusion of long term care and dual eligible data in the ACO metrics. This phase includes Medicaid performing a detailed review of the methodologies and working with Treo, Wellmark, and the TA vendor to finalize the model design. The TA vendor will support DHS in determining and writing appropriate State Plan Amendments or Waivers. We assume this phase will also include TA from CMS.

The Stakeholder Feedback phase 1/1/13-3/31/13 will include outreach to stakeholders, meetings and gathering public input. This phase also includes the Legislative process. We expect the Advisory Committee to meet every six weeks.

The final phase of developing the State Health Care Innovation Plan and Model Testing proposal 3/1/12 – 6/3/12 will involve finalizing and writing the plans.